



MRI INFORMATION FORM

Name _____ DOB _____ Sex _____ Weight _____

Requesting Physician _____ Family Physician _____

What symptoms are you experiencing? _____

Was there any recent trauma to the affected area? _____

Have you ever had cancer? If so, please specify. _____

Was there any previous testing for this affected area? _____

If so, when and where was it performed? _____

The following items can interfere with MRI imaging. Some can be hazardous to your safety.

PLEASE LET US KNOW IF YOU HAVE ANY OF THE FOLLOWING

Y / N	Cardiac Pacemaker	Y / N	Hearing Aids
Y / N	Stent or wire in blood vessels/shunts	Y / N	Cochlear, otologic, or other ear implants
Y / N	Artificial heart valve	Y / N	Prior gunshot wound
Y / N	Brain aneurysm clips	Y / N	Facial injury from metal
Y / N	Prosthesis (orbital, joint or penile)	Y / N	Welding/metal slivers/shavings in eyes
Y / N	Metallic implants	Y / N	IUD/Pessary
Y / N	Artificial limbs or joint replaced	Y / N	Pregnant or breast feeding
Y / N	Insulin or drug infusion pump	Y / N	Trans dermal patch/Neurostimulators

Are you being treated for kidney disease, renal failure, or insufficiency? Y/N _____

Females only, date of last cycle? _____

I have answered the above questions to the best of my knowledge and understand the information presented to me.

Patient Signature _____ DATE _____

Technologist Signature _____ DATE _____